



## APPEAL REQUEST FORM Healthy Way LA

(An appeal may only be made after receiving a Notice of Action)

Note: If you cannot read or understand this form, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

### MEMBER INFORMATION

Member Name (Last)	(First)	Birth Date:	Mo.	Day	Yr.	HWLA Member ID #
						DMH IS #
Address (Street)	(City)	(State)				(ZIP Code)
Telephone (Home)	(Cell )					(Alternate)
Name of person completing form, if different from member name					(Daytime Telephone)	

<b>Please attach a copy of your Notice of Action</b>	Notice of Action Date:
Name of Provider/Clinic:	
Please tell us why you do not agree with the decision about your mental health services. You may attach any papers that support your appeal. <b>For additional space use page 2 of this form or add another piece of paper.</b>	
<b>Answer this question only if you had a service or treatment that has been stopped or limited</b> Are you asking for the stopped or limited services to keep going during the appeal? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, then you may have to pay for the cost of services if you lose the appeal.	
If you think your situation is urgent, and waiting 45 days will put your life or health at serious risk, tell us what may happen without a quick decision:	
Does your Provider agree that this situation is urgent? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I understand that the Department of Mental Health Patients' Rights will contact me within forty-five (45) days to give me a decision on my appeal.	
Signature of member/member's representative	Date

## APPEAL REQUEST FORM/Healthy Way LA

Please tell us why you do not agree with the decision about your mental health services. **For additional space add another piece of paper.**

**PLEASE RETURN THIS FORM TO THE DEPARTMENT OF MENTAL HEALTH PATIENTS' RIGHTS BY DOING ONE OF THE FOLLOWING:**

- Fax it to the Department of Mental Health Patients' Rights at (213) 365-2481
- Return form in person to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020
- Mail it to Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020

### INTERNAL USE ONLY

#### (Complete only if a Potential Expedited Appeal)

Definition: An expedited appeal is one that involves an issue that could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Member was told that the expedited appeal would be decided within three working days of its receipt?

Yes ☐ No ☐

Member was told to provide supporting documentation by the next working day?

Yes ☐ No ☐

Date Appeal Acknowledgement Given:

1. DMH Provider (Directly Operated, LE, PPP/FQHC, CAU):

2. HWLA Member ID:

3. DMH IS #:

4. Appeal received : In Person ☐ By Phone ☐ By Mail ☐

By Fax ☐

Appeal Received By:

Time:

Date: